		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0023382

Facility Name: Eden Village Care Center

Address: 400 South Station Road (Number) Glen Carbon (City) 62034 (Zip Code)

County: Madison

Telephone Number: (618) 288-5014 **Fax #** (618) 288-0206

IDPA ID Number: 37-10332262001

Date of Initial License for Current Owners: 5/14/1979

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(C)(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Allan B. Larson, CPA **Telephone Number:** (314) 336-3679

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Jane Rubin

(Title) Executive Director

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Allan B. Larson, CPA, Principal

(Firm Name & Address) Larson, Allen, Weishair & Co., LLP, 12801 Flushing Meadows Drive, Suite 100

(Telephone) (314) 336-3600 Fax # (314) 336-3650

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	138	Skilled (SNF)	138	50,370	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	138	TOTALS	138	50,370	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,442	26,591	3,479	46,512	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,442	26,591	3,479	46,512	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.34%

D. How many bed-hold days during this year were paid by Public Aid? (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Outpatient Therapy

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 5/14/1979

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/14/1979 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 138 and days of care provided

Medicare Intermediary Mutual of Omaha, P.O. Box 1602, Omaha, NE 68101

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	304,009	33,090	7,191	344,290	(7,914)	336,376	(36,259)	300,117			1
2	Food Purchase		300,336		300,336		300,336	(31,630)	268,706			2
3	Housekeeping	206,768	36,886	8,553	252,207		252,207	(125,797)	126,410			3
4	Laundry	92,192	15,426		107,618		107,618	(39,886)	67,732			4
5	Heat and Other Utilities			321,603	321,603		321,603	(160,410)	161,193			5
6	Maintenance	154,570	18,975	161,646	335,191		335,191	(167,188)	168,003			6
7	Other (specify):*											7
8	**TOTAL General Services**	757,539	404,713	498,993	1,661,245	(7,914)	1,653,331	(561,170)	1,092,161			8
	B. Health Care and Programs											
9	Medical Director			17,550	17,550		17,550		17,550			9
10	Nursing and Medical Records	2,062,374	210,336	77,199	2,349,909	(86,497)	2,263,412		2,263,412			10
10a	Therapy		1,399	332,390	333,789		333,789		333,789			10a
11	Activities	142,454	5,522	5,701	153,677		153,677		153,677			11
12	Social Services	39,931	1,957	762	42,650		42,650		42,650			12
13	Nurse Aide Training			11,761	11,761		11,761		11,761			13
14	Program Transportation	36,416	2,598	2,273	41,287		41,287	(15,302)	25,985			14
15	Other (specify):* Senior Fit	23,786	588	58,332	82,706		82,706	(82,706)				15
16	**TOTAL Health Care and Programs**	2,304,961	222,400	505,968	3,033,329	(86,497)	2,946,832	(98,008)	2,848,824			16
	C. General Administration											
17	Administrative	108,495	382	19,965	128,842		128,842	(52,467)	76,375			17
18	Directors Fees											18
19	Professional Services			90,372	90,372		90,372	(10,822)	79,550			19
20	Dues, Fees, Subscriptions & Promotions			31,355	31,355		31,355	(21,517)	9,838			20
21	Clerical & General Office Expenses	198,261	12,036	81,822	292,119		292,119	(108,267)	183,852			21
22	Employee Benefits & Payroll Taxes			728,729	728,729	7,914	736,643	(19,468)	717,175			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,407	12,407		12,407	(2,442)	9,965			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			150,014	150,014		150,014	(12,625)	137,389			26
27	Other (specify):* Marketing	31,071	1,368	19,460	51,899		51,899	(51,899)				27
28	**TOTAL General Administration**	337,827	13,786	1,134,124	1,485,737	7,914	1,493,651	(279,507)	1,214,144			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,400,327	640,899	2,139,085	6,180,311	(86,497)	6,093,814	(938,685)	5,155,129			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Eden Village Care Center #0023382 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			542,816	542,816		542,816	(257,668)	285,148			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			89,664	89,664		89,664	(4,339)	85,325			32
33	Real Estate Taxes			43,587	43,587		43,587	(43,587)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			676,067	676,067		676,067	(305,594)	370,473			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					86,497	86,497		86,497			39
40	Barber and Beauty Shops		3,908	43,003	46,911		46,911		46,911			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			75,555	75,555		75,555		75,555			42
43	Other (specify):*	93,334		7,828	101,162		101,162	(101,162)				43
44	**TOTAL Special Cost Centers**	93,334	3,908	126,386	223,628	86,497	310,125	(101,162)	208,963			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,493,661	644,807	2,941,538	7,080,006		7,080,006	(1,345,441)	5,734,565			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients	(82,706)	15		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,715)	17		24
25	Fund Raising, Advertising and Promotional	(21,517)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,236,503)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,345,441)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,345,441)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs	x		86,497	10	43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 86,497		47

STATE OF ILLINOIS

Eden Village Care Center

ID# 0023382

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Depreciation-Non-Care Assets (RC & Autos)	$ (257,668)	30	1
2	Non-Allowable Travel/Seminars (ALFA)	(2,442)	24	2
3	Marketing	(51,899)	27	3
4	Real Estate Taxes	(43,587)	33	4
5	Interest Expense-RC	(4,339)	32	5
6	Legal Fees-RE Exemption (RC)	(10,822)	19	6
7	RC (Retirement Center)-Dietary	(36,259)	1	7
8	RC-Food	(31,630)	2	8
9	RC-Housekeeping	(125,797)	3	9
10	RC-Laundry	(39,886)	4	10
11	RC-Heat & Utilities	(160,410)	5	11
12	RC-Maintenance	(167,188)	6	12
13	RC-Program Transportation	(15,302)	14	13
14	RC-Administrative	(47,752)	17	14
15	RC-Clerical & Office	(108,267)	21	15
16	RC-Employee Benefits/PR Taxes	(19,468)	22	16
17	RC-Insurance	(12,625)	26	17
18	RC-Direct Expenses	(101,162)	43	18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,236,503)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eden Village Care Center **#** 0023382 **Report Period Beginning:** 1/1/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(36,259)	0	0	0	0	0	0	0	0	0	0	(36,259)	1
2	Food Purchase	(31,630)	0	0	0	0	0	0	0	0	0	0	(31,630)	2
3	Housekeeping	(125,797)	0	0	0	0	0	0	0	0	0	0	(125,797)	3
4	Laundry	(39,886)	0	0	0	0	0	0	0	0	0	0	(39,886)	4
5	Heat and Other Utilities	(160,410)	0	0	0	0	0	0	0	0	0	0	(160,410)	5
6	Maintenance	(167,188)	0	0	0	0	0	0	0	0	0	0	(167,188)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(561,170)	0	0	0	0	0	0	0	0	0	0	(561,170)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(15,302)	0	0	0	0	0	0	0	0	0	0	(15,302)	14
15	Other (specify):*	(82,706)	0	0	0	0	0	0	0	0	0	0	(82,706)	15
16	**TOTAL Health Care and Programs**	(98,008)	0	0	0	0	0	0	0	0	0	0	(98,008)	16
	C. General Administration													
17	Administrative	(52,467)	0	0	0	0	0	0	0	0	0	0	(52,467)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,822)	0	0	0	0	0	0	0	0	0	0	(10,822)	19
20	Fees, Subscriptions & Promotions	(21,517)	0	0	0	0	0	0	0	0	0	0	(21,517)	20
21	Clerical & General Office Expenses	(108,267)	0	0	0	0	0	0	0	0	0	0	(108,267)	21
22	Employee Benefits & Payroll Taxes	(19,468)	0	0	0	0	0	0	0	0	0	0	(19,468)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,442)	0	0	0	0	0	0	0	0	0	0	(2,442)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(12,625)	0	0	0	0	0	0	0	0	0	0	(12,625)	26
27	Other (specify):*	(51,899)	0	0	0	0	0	0	0	0	0	0	(51,899)	27
28	**TOTAL General Administration**	(279,507)	0	0	0	0	0	0	0	0	0	0	(279,507)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(938,685)	0	0	0	0	0	0	0	0	0	0	(938,685)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Eden Village Care Center **#** 0023382 **Report Period Beginning:** 1/1/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(257,668)	0	0	0	0	0	0	0	0	0	0	(257,668)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,339)	0	0	0	0	0	0	0	0	0	0	(4,339)	32
33	Real Estate Taxes	(43,587)	0	0	0	0	0	0	0	0	0	0	(43,587)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(305,594)	0	0	0	0	0	0	0	0	0	0	(305,594)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(101,162)	0	0	0	0	0	0	0	0	0	0	(101,162)	43
44	**TOTAL Special Cost Centers**	(101,162)	0	0	0	0	0	0	0	0	0	0	(101,162)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,345,441)	0	0	0	0	0	0	0	0	0	0	(1,345,441)	45

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		N/A				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Village of Glen Carbon		X	Construction & Equipment		12/31/96	$ 2,300,000	$ 1,445,000	10/01/2011	5.1-5.8%	$ 85,325	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 2,300,000	$ 1,445,000			$ 85,325	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,300,000	$ 1,445,000			$ 85,325	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	45,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	43,587	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,413)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	45,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	43,587	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	19,392	8
	1999	26,526	9
	2000	38,828	10
	2001	41,968	11
	2002		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Eden Village Care Center COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0023382

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (618) 288-5014 FAX #: (618) 288-0206

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-2-15-26-02-202-165	Eden Village Subd 1st Addn Lot 1	$ 33,369.79	$
2.	14-2-12-26-02-202-096	Cottonwood Trace PT Lot 3	$ 72.46	$
3.	14-2-15-26-02-202-097	Cottonwood Trace PT Lot 2	$ 9,218.68	$
4.	14-2-15-26-02-202-101	Cottonwood Trace-First Addn LT PT8	$ 900.85	$
5.	14-1-15-26-02-202-098.001	NE/C NE	$ 24.82	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 43,586.60	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 53,240 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Eden Retirement Center, Independent Living Facility (80 apartments; 36 duplex units)
Eden Childcare Center, Child Daycare Facility

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land-SNF		1979	$ 166,295	1
2					2
3	TOTALS			$ 166,295	3

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	138		1979	1979	$ 2,008,520	$ 66,950	30	$ 66,950	$	$ 1,651,352	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Landscaping-398			1993	809	41	10	41		809	10
11	Flower bed irrigation system-786			1997	2,450	163	15	163		1,007	11
12	Parking lot-13			1979	62,453		10			62,453	12
13	Alarm system-29			1979	1,193		10			1,193	13
14	Additions-106			1985	28,766	959	30	959		17,500	14
15	Roof-239			1989	21,453	1,073	20	1,073		15,554	15
16	Office addition-269			1990	34,575	1,152	30	1,152		15,366	16
17	Interior office walls-280			1991	3,102	124	25	124		1,613	17
18	Gas pipe-283			1991	5,850	234	25	234		3,023	18
19	Parking lot-311			1991	8,447	563	15	563		6,852	19
20	Floor-kitchen-308			1991	3,046	152	20	152		1,865	20
21	Blocks-parking lot-279			1991	391	26	15	26		338	21
22	Building remodeling-348			1991	104,840	4,194	25	4,194		46,829	22
23	Paved entrance drive-330			1992	1,890	126	15	126		1,470	23
24	Gutters-399			1993	293	15	20	15		154	24
25	Fence-400			1993	700	47	15	47		490	25
26	Patio roof-401			1993	3,285	164	20	164		1,725	26
27	Roof-424			1993	10,956	548	20	548		5,615	27
28	Signs-441			1993	6,956	580	12	580		5,846	28
29	Remodel hall I-425			1993	23,174	927	25	927		9,502	29
30	Remodel hall III-442			1993	20,060	802	25	802		8,091	30
31	Walkpads-365			1993	1,085	54	20	54		596	31
32	Driveway seal-433			1993	950	48	20	48		484	32
33	Parking lot-482			1994	3,188	159	20	159		1,515	33
34	Remodel hall III-454			1994	10,620	425	25	425		4,177	34
35	Improvements-462			1994	2,896	193	15	193		1,882	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Remodel hall V-455	1994	$ 8,141	$ 325	25	$ 325	$	$ 3,202	37
38	Improvements-506	1994	650	43	15	43		400	38
39	Improvements-519	1994	138	9	15	9		83	39
40	Crash Rails-525	1994	3,070	205	15	205		1,859	40
41	Improvements-608	1995	2,841	142	20	142		1,160	41
42	Rubber roof installation-583	1995	23,522	1,176	20	1,176		9,899	42
43	Rubber roof installation-609	1995	23,522	1,176	20	1,176		9,605	43
44	Shower room improvements-619	1995	6,285	314	20	314		2,540	44
45	Improvements-541	1995	2,360	118	20	118		1,042	45
46	Improvements room 501-554	1995	1,800	90	20	90		788	46
47	Improvements room 403 405 407-555	1995	5,400	270	20	270		2,363	47
48	Improvements room 400 401-556	1995	4,035	202	20	202		1,765	48
49	Improvements room 409 411 413-567	1995	5,400	270	20	270		2,317	49
50	Improvements room 408 410 412-572	1995	5,754	288	20	288		2,446	50
51	Improvements room 402 404 406-584	1995	5,594	280	20	280		2,355	51
52	Design & engineering cost-546	1995	4,410	221	20	221		1,930	52
53	Improvements-622	1996	1,867	93	20	93		747	53
54	Crash rails-627	1996	2,829	189	15	189		1,494	54
55	Remodel rooms 509 511 513-635	1996	7,080	354	20	354		2,744	55
56	Remodel rooms 503 505 507-641	1996	7,080	354	20	354		2,744	56
57	Install phone jacks-645	1996	210	21	10	21		161	57
58	Remodel rooms 502 504 506-650	1996	7,080	354	20	354		2,714	58
59	Install phone jacks-656	1996	210	21	10	21		159	59
60	Remodel rooms 508 510 512-668	1996	7,080	354	20	354		2,655	60
61	Remodel rooms 209 211 213-684	1996	7,080	354	20	354		2,596	61
62	Remodel rooms 203 205 207-699	1996	7,080	354	20	354		2,567	62
63	Remodel rooms 200 202 204-708	1996	7,080	354	20	354		2,537	63
64	Remodel rooms 206 208 210-715	1996	7,080	354	20	354		2,508	64
65	Remodel room 212-719	1996	2,360	118	20	118		836	65
66	Roof repair-769	1997	3,550	177	20	177		1,124	66
67	Prep and paint walls-1/2 -500	1994	13,333	1,333	10	1,333		12,554	67
68	Vinyl fence-852	1998	3,731	249	15	249		1,472	68
69	Parking lot asphalt-922	1998	18,949	1,895	10	1,895		10,106	69
70	TOTAL (lines 4 thru 69)		$ 2,578,549	$ 91,776		$ 91,776	$	$ 1,960,773	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,578,549	$ 91,776		$ 91,776	$	$ 1,960,773	1
2	Expansion carpet & wallcovering-806	1998	14,587		5			14,587	2
3	Carpet-admin & chapel-853	1998	19,121	319	5	319		19,121	3
4	Wall covering-lobby-877	1998	876	88	10	88		519	4
5	Walk off pad-873	1998	1,514	101	15	101		597	5
6	Wall covering-therapy-881	1998	1,603	160	10	160		935	6
7	Wall coverings-7 rooms-898	1998	17,500	1,750	10	1,750		9,625	7
8	Expansion construction-admin & patient rooms-807	1998	895,205	22,380	40	22,380		134,281	8
9	Expansion construction-therapy center-850	1998	522,203	13,055	40	13,055		77,242	9
10	Construction-eng & archit fees-851	1998	126,455	4,215	30	4,215		24,939	10
11	Roof repair-886	1998	7,452	745	10	745		4,285	11
12	Design cost-993	1999	734	24	30	24		120	12
13	Corner protectors-1018	1999	1,701	113	15	113		529	13
14	17 fire/smoke dampers-985	1999	22,104	1,474	15	1,474		7,368	14
15	Electrical circuit installations-1037	1999	447	29	15	29		134	15
16	Wall coverings: halls 1 & 2, nurses station-997,1004,1008,1024,106	1999	4,412	441	10	441		2,060	16
17	Alarm system repair-1025	1999	1,840	123	15	123		562	17
18	Sprinkler system improv.-1021	1999	3,135	209	15	209		958	18
19	Engineering consulting-1057	1999	899	60	15	60		255	19
20	Wallcoverings: halls 3 & 4, main hall-971 & 972	1999	10,329	1,033	10	1,033		5,165	20
21	Crash rail-973	1999	25,475	1,698	15	1,698		8,491	21
22	Wallcoverings: dining room, alzh dining area-1009 & 1019	1999	9,925	992	10	992		4,677	22
23	Alzheimers construction-1026	1999	504,922	12,623	40	12,623		57,856	23
24	100' vinyl fence-1069	1999	1,383	92	15	92		384	24
25	Signage program-1000	1999	20,523	1,368	15	1,368		6,613	25
26	Courtyard landscaping-1044	1999	8,900	890	10	890		3,931	26
27	Pond sidewalk-1046	1999	3,485	232	15	232		1,026	27
28	Monumental plaque-987	1999	148	15	10	15		74	28
29	Custom door, frame, hinges-1103	2000	555	56	10	56		218	29
30	Final CC renovation payment-1113	2000	11,000	275	40	275		1,031	30
31	Carpet-service hall-1165	2000	2,444	489	5	489		1,508	31
32	Chair rails-1167	2000	5,843	584	10	584		1,801	32
33	Wallpaper & flooring, activity room-1150	2000	1,537	307	30	307		999	33
34	TOTAL (lines 1 thru 33)		$ 4,826,806	$ 157,716		$ 157,716	$	$ 2,352,664	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,826,806	$ 157,716		$ 157,716	$	$ 2,352,664	1
2	Linoleum, activity room-1161	2000	5,523	1,104	5	1,104		3,497	2
3	Sidewalk-1162	2000	4,235	212	20	212		671	3
4	Alzheimers construction-final	2001	31,865	2,124	15	2,124		6,019	4
5	Landscaping-CC/Therapy	2001	4,865	486	10	486		1,256	5
6	Painting-main hall & lobby bathrooms	2001	1,774	177	10	177		458	6
7	RipRap (rock)-lake	2001	1,109	111	10	111		277	7
8	Parking lot sealing/striping-CC/Therapy	2001	7,183	718	10	718		1,616	8
9	Install delayed egress on doors	2001	3,400	340	10	340		708	9
10	Trees-removal	2001	585	59	10	59		137	10
11	Roof repairs	2001	3,148	315	10	315		813	11
12	Heat tape in down spouts	2001	4,905	491	10	491		1,268	12
13	Upgrade parking lighting-0955	1998	3,750	250	15	250		1,271	13
14	Nurse stn A/C unit	2001	916	92	10	92		237	14
15	Emplovee lounge-2081	2002	3,150	126	25	126		147	15
16	Front receptionist desk-2084	2002	2,400	96	25	96		104	16
17	Nurses station hall 6-2085	2002	800	32	25	32		35	17
18	Nurses station hall 6-2086	2002	2,850	114	25	114		124	18
19	Removal of nurse station-3003	2003	875	35	25	35		35	19
20	Carpet by aviary-3021	2003	2,884	106	25	106		106	20
21	Restripe parking lot-3028	2003	735	55	10	55		55	21
22	Landscape lake area-3068	2003	671	11	10	11		11	22
23	Landscape main entrance-3070	2003	2,625	44	10	44		44	23
24	Walls for art/music therapy room-3076	2003	2,170	9	20	9		9	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,919,224	$ 164,823		$ 164,823	$	$ 2,371,562	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,628,962	$ 114,807	$ 114,807	$	various	$ 1,078,132	71
72	Current Year Purchases	80,306	5,518	5,518		various	5,518	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,709,268	$ 120,325	$ 120,325	$		$ 1,083,650	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Business	1990 Van - 275	1990	$ 40,188	$	$	$	4	$ 40,188	76
77										77
78										78
79										79
80	TOTALS			$ 40,188	$	$	$		$ 40,188	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,834,975	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 285,148	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 285,148	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,495,400	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Retirement Center Apts/Duplexes	$ 6,293,048	$ 248,935	$ 3,603,553	86
87	Retirement Center Land	107,183			87
88	Other Autos	61,474	8,733	33,834	88
89					89
90					90
91	TOTALS	$ 6,461,705	$ 257,668	$ 3,637,387	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ ____ Description: ____
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE 111

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 44

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$ 3,570	$ 8,726	$	$ 12,296
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		550		550
9	TOTALS	$ 3,570	$ 9,276	$	$ 12,846
10	SUM OF line 9, col. 1 and 2 (e)	$ 12,846			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	22
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	9
2. From other facilities (f)	
TOTAL TRAINED	31

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$ 102,102	$		$ 102,102	1
2	Licensed Speech and Language Development Therapist		hrs			35,544			35,544	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			191,280			191,280	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				86,497		86,497	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$ 328,926	$ 86,497		$ 415,423	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,939,512	$	1
2	Cash-Patient Deposits	146,743		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,000)	530,980		3
4	Supply Inventory (priced at cost)	21,254		4
5	Short-Term Investments	199,000		5
6	Prepaid Insurance	27,834		6
7	Other Prepaid Expenses	333		7
8	Accounts Receivable (owners or related parties)	100,000		8
9	Other(specify): Interest Receivable	1,313		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,966,969	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	273,478		13
14	Buildings, at Historical Cost	10,622,153		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,411,667		16
17	Accumulated Depreciation (book methods)	(7,132,787)		17
18	Deferred Charges	10,408		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,184,919	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,151,888	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 86,823	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,590		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	174,184		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,138		31
32	Accrued Real Estate Taxes(Sch.IX-B)	45,000		32
33	Accrued Interest Payable	8,596		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Prelease/Rental Deposits	81,700		36
37	Other Accrued Expenses	82,381		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 485,412	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,445,000		41
42	Deferred Compensation	245,710		42
	Other Long-Term Liabilities(specify):			
43	Deferred Entrance Fees	2,732,024		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,422,734	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,908,146	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,243,742	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,151,888	$	48

***(See instructions.)**

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,825,552	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,825,552	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	418,190	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 418,190	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,243,742	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,566,550	1
2	Discounts and Allowances for all Levels	(771,352)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,795,198	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	37,653	5
6	Therapy	17,929	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 55,582	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	61,265	13
14	Non-Patient Meals	91,659	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,344	19
20	Radiology and X-Ray		20
21	Other Medical Services	98,833	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 254,101	23
	D. Non-Operating Revenue		
24	Contributions	21,117	24
25	Interest and Other Investment Income***	54,150	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 75,267	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Retirement Center (Apt/Duplex)	1,288,127	28
28a	Miscellaneous	29,921	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,318,048	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,498,196	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,661,245	31
32	Health Care	3,033,329	32
33	General Administration	1,485,737	33
	B. Capital Expense		
34	Ownership	676,067	34
	C. Ancillary Expense		
35	Special Cost Centers	148,073	35
36	Provider Participation Fee	75,555	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,080,006	40
41	**Income before Income Taxes (line 30 minus line 40)****	418,190	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 418,190	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing		4,168	$ 103,557	$ 24.85	1
2	Assistant Director of Nursing					2
3	Registered Nurses		12,449	211,407	16.98	3
4	Licensed Practical Nurses		32,989	551,885	16.73	4
5	Nurse Aides & Orderlies		104,613	1,144,325	10.94	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director		11,556	142,454	12.33	9
10	Activity Assistants					10
11	Social Service Workers		7,024	76,347	10.87	11
12	Dietician					12
13	Food Service Supervisor		4,464	60,606	13.58	13
14	Head Cook		30,794	243,403	7.90	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers		16,741	154,570	9.23	17
18	Housekeepers		24,784	206,768	8.34	18
19	Laundry		11,051	92,192	8.34	19
20	Administrator		2,082	70,345	33.79	20
21	Assistant Administrator		2,080	38,150	18.34	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical		14,472	198,261	13.70	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records		5,308	51,200	9.65	31
32	Other Health C: Senior Fit		2,084	23,786	11.41	32
33	Other(specify) Marketing & RC		13,446	124,405	9.25	33
34	TOTAL (lines 1 - 33)		300,105	$ 3,493,661 *	$ 11.64	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	168	$ 6,510	1-3	35
36	Medical Director	72	17,550	9-3	36
37	Medical Records Consultant	43	1,892	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,138	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	11	474	11-3	44
45	Social Service Consultant	11	474	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	401	$ 28,038		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	0	$ 0		50
51	Licensed Practical Nurses	5	150		51
52	Nurse Aides	2,354	49,142	10-3	52
53	TOTAL (lines 50 - 52)	2,359	$ 49,292		53

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Jane Hamiton Rubin	Exec Director		70,345
Janet Heepke	Admissions		38,150
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 108,495

B. Administrative - Other

Description	Amount
Bad Debt Expense	$ 4,715
Amort of Loan Cost	2,025
Eden Alternative Training, etc.	12,114
Miscellaneous	1,111
TOTAL (agree to Schedule V, line 17, col. 3)	$ 19,965
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
Greensfelder	Legal	4,161
McCarthy & Assoc	Legal	10,822
Farrell, Hunter, Hamilton	Legal	418
Coffey	Legal	3,559
Larson, Allen, Weishair	Acctg/Consulting	40,031
Moore Diversified Service	Acctg/Consulting	31,061
Chestnut Employee Assistance	Consulting	320
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 90,372

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 162,599
Unemployment Compensation Insurance	13,433
FICA Taxes	274,593
Employee Health Insurance	231,040
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(K)	29,118
General Incentives	17,946
Employee Meals	7,914
Retirement Center Benefits	(19,468)
TOTAL (agree to Schedule V, line 22, col.8)	$ 717,175

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Marketing & Advertising	21,517
Dues & Subscriptions	9,838
Less: Public Relations Expense	(7,833)
Non-allowable advertising	(13,684)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,838

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 2,693
In-State Travel	1,789
Seminar Expense	5,483
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,965

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Eden Village Care Center # 0023382 **Report Period Beginning:** 1/1/2003 **Ending:** 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? _____

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LSN - $8,545

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 37,783 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? _____ YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 75,555
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 7,914 Has any meal income been offset against related costs? No Indicate the amount. $ N/A

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Larson, Allen, Weishair & Co, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.